

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00782

787
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37		d. STREET ADDRESS 306 Cannon Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes (4 days)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA First MAY Middle BRATCHER Last		4. DATE OF DEATH Month January Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1902
9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Turner		14. MOTHER'S MAIDEN NAME Gertrude Brown Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 217-12-4738	
17. INFORMANT Hospital Records		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 331X DUE TO Arterial Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) several years DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1958 , to January 4, 1958 , that I last saw the deceased alive on January 5, 1958 , and that death occurred at 11:55P M., from the causes and on the date stated above.		DATE SIGNED 1/5/58	
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Maryland	
PHYSICIAN'S NAME (Type) ROBERT W. FARR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/58	
22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery		22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JAN 8 '58		24b. REGISTRAR'S SIGNATURE Al. Lewis	

J. A. NUSSBAUM

8361 8 NV

RECEIVED

797 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SASSAFRAS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SASSAFRAS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PERRY HENRY BROWN</u>				4. DATE OF DEATH Month Day Year <u>JAN. 25 1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22, 1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION BUILDING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>PERRY BROWN</u>			
14. MOTHER'S MAIDEN NAME <u>MARY WARNER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>212-12-3757</u>				17. INFORMANT Address <u>GEORGE ANN BROWN, SASSAFRAS, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Insufficiency & decomp.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 - 2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 24</u> , 1958, to <u>Jan 25</u> , 1958, that I last saw the deceased alive on <u>Jan 24</u> , 1958, and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <u>Millington</u> <u>1/27/58</u>							
ACTUAL PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
22b. DATE THEREOF <u>1/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY HENRY CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GOLT, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>				24a. REC'D BY REGISTRAR <u>Jan 21 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
SIGNS AND SYMPTOMS		TREATMENT	
HISTORY		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU OF HEALTH

JAN 31 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00784

788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Golt		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent and Queen Anne Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Robert Middle Byard Last Byard				4. DATE OF DEATH Month January Day 29 Year 19 58			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Dec. 30, 1930			
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27		IF UNDER 24 HRS. Hours 27 Min. 27			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME Phillip Byard				14. MOTHER'S MAIDEN NAME Mattie Goldsberry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Hospital chart		17. INFORMANT Address Hospital chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion and shock DUE TO Deceased was attacked about 11:00 P.M. near his home in Golts, Md. Brought to the Kent and Queen Anne Hosp. in Chestertown 2:30 A.M. He was found to be suffering from multiple lacerations of the head due to blows with a club. He was severely shocked from exposure to cold and from his injuries. Death occurred 6:30 A.M. (b) 983X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH 5 hours </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) with a club. He was severely shocked from exposure to cold and from his injuries. Death occurred 6:30 A.M.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 1/28/58 Hour 1:00 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Golts, Md.			
20f. (City or town) Golts		(County) Kent		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/58		22c. NAME OF CEMETERY OR CREMATORY Laker Cem.			
22d. LOCATION (City, town, or county) Middletown		(State) Md.		24a. REC'D BY REGISTRAR FEB 7 1958			
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway				ADDRESS Middletown Md.			
24b. REGISTRAR'S SIGNATURE W. J. ...				DATE FEB 7 1958			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURKAY K. B.

FEB 7 1958

RECEIVED

798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON				c. LENGTH OF STAY IN 1b x MILLINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) CHARLES S. CHURCH				4. DATE OF DEATH JAN. 30 1958			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 21, 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-DISTRICT MAN		10b. KIND OF BUSINESS OR INDUSTRY E. S. P. SERVICE		11. BIRTHPLACE (State or foreign country) BERGAN, N. Y.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE H. CHURCH				14. MOTHER'S MAIDEN NAME BELLE FARM HALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-03-8658		17. INFORMANT MRS. HELEN B. CHURCH, MILLINGTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Prostatic malignancy DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 years 4 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury			
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from OCT- 1953 , to JAN 30, 1958 , that I last saw the deceased alive on JAN 30, 1958 , and that death occurred at 6:10 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE H. H. Hamilton				M.D. Millington Md		1/31/58	
PHYSICIAN'S NAME (Type) H. H. HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/1/58		22c. NAME OF CEMETERY OR CREMATORY MILLINGTON CEM.		22d. LOCATION (City, town, or county) (State) MILLINGTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				ADDRESS Millington, MD.		24a. REC'D BY REGISTRAR Feb 6 1958	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. 1

FEB 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galena (Georgetown)</u> c. LENGTH OF STAY IN 1b <u>Entire life</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galena (Georgetown)</u> x d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>WILLARD BORTON EDWARDS</u> First Middle Last				4. DATE OF DEATH <u>January 5 1958</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 31, 1894</u> 9. AGE (In years for birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Knig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-22-3936</u>		17. INFORMANT <u>Mrs. Antoinette Stacy Edwards</u> Address <u>Galena Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unknown, but probably cardiac.</u> 795.5 DUE TO <u>went to work 6:45 pm 1/4/58. Last seen alive 8:30 pm 1-4-58</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead 6:45 am 1/5-58</u> (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Short</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Robert W. Farr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/5/58</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Jan 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellow</u>				ADDRESS <u>Millington Md.</u>			
24a. REC'D BY REGISTRAR <u>JAN 13 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

789

CERTIFICATE OF DEATH

00788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 34 hours			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann's				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas B Elbourn				4. DATE OF DEATH January 4 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1902		9. AGE (In years last birthday) yrs. 55	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Fishing, dockbuilding		11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas J. Elbourn				14. MOTHER'S MAIDEN NAME Sara Kendall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm of abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 36 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2 , 19 58 , to 1-4 , 19 58 , that I last saw the deceased alive on 1-4 , 19 58 , and that death occurred at 12:55a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.C. Dick				ADDRESS (Street, city or town, state) M.D. Chestertown, Maryland		DATE SIGNED 1-4-58	
PHYSICIAN'S NAME (Type) A.C. Dick							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/4/58		22c. NAME OF CEMETERY OR CREMATORY ST. PAUL		22d. LOCATION (City, town, or county) (State) Fairlee, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR JAN 6 1958	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

BUREAU V. S.

JAN 8 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

790

CERTIFICATE OF DEATH

Reg. Dist. No.

00787

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Spring Ave.				d. STREET ADDRESS 110 Spring Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite Cree Eliason				4. DATE OF DEATH Month Day Year Jan. 5 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 6 1889		9. AGE (In years last birthday) 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Ft. McHenry, Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John K. Cree				14. MOTHER'S MAIDEN NAME Agnes Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Thos. W. Eliason, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable acute coronary insufficiency with a few minutes 420.1 DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis & aortic stenosis at least 6 years DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/19 , 19 57 , to 1/5 , 19 58 that I last saw the deceased alive on 1/5 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Robert W. Farr				M.D. Chestertown, Md. 1/6/58			
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7/58		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Marvin V. Williams- Chestertown, Md.				24a. REC'D BY REGISTRAR Jan 9 '58		24b. REGISTRAR'S SIGNATURE Research	

JAN 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00789

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLEE</u>	c. LENGTH OF STAY IN 1b <u>LIFE</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairlee (rural chestertown)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>JAMES</u> Middle <u>FRENCH</u> Last			4. DATE OF DEATH Month <u>JAN</u> Day <u>2</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>tenant FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>u.s.a</u>					

13. FATHER'S NAME <u>James Alfred French</u>	14. MOTHER'S MAIDEN NAME <u>anna Reese Venables</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>214-36-5446</u>	17. INFORMANT Address <u>Mrs Mary Hatcher, Chestertown, Md</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Natural causes, but unknown ones</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>probably congestive heart failure</u> (c) <u>stating the underlying cause lost.</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Don't know</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>was found dead in bed, was not related to the terminal disease condition given in part I (a)</u> <u>1-1-58, last seen alive 11:34 pm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <input type="checkbox"/> p. m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE <u>Robert W. Farr</u>	DATE SIGNED <u>1/2/58</u>
EXAMINER'S NAME (Type) <u>ROBERT W. FARR</u>	
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>nr. - Chestertown, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>	ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>	24b. REGISTRAR'S SIGNATURE <u>A. J. Hedrick</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 3 1958
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

791

CERTIFICATE OF DEATH

00790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 1 hour d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown (Rural) d. STREET ADDRESS RFD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes First Middle Last Goldsborough		4. DATE OF DEATH Month Jan Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April March 26, 1904
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wright		14. MOTHER'S MAIDEN NAME Mary Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-7879	
17. INFORMANT Hospital records		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrad ranial hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8-9 hours Several years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/15 , 19 58 , to 1/28 , 19 58 , that I last saw the deceased alive on 1/28/58 , and that death occurred at 4:40 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/29/58 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) ROBERT W. FARR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. I, 1958	
22c. NAME OF CEMETERY OR CREMATORY Broad Neck Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown. xdm Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walby		24a. REC'D BY REGISTRAR JAN 30 '58	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Alb. Leach	

4

ENVIRONMENTAL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00791

801

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond</u>		c. LENGTH OF STAY IN 1b <u>70 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willis K. Hackett</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1867</u>
9. AGE (In years last birthday) yrs. <u>90</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cannery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew J. Hackett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Cavender</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. E. K. Jones</u>		Address <u>Still Pond, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-23</u> , 19 <u>58</u> , to <u>1-25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-23-58</u> , 19 <u>58</u> , and that death occurred at <u>3:00a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Maryland</u> DATE SIGNED <u>1-25-58</u> ACTUAL SIGNATURE <u>A. C. Dick</u> M. D. _____ PHYSICIAN'S NAME (Type) <u>A. C. Dick</u> M. D. <u>Chestertown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		ADDRESS <u>Still Pond, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Adel Smith</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

STATE OF MARYLAND

DEATH CERTIFICATE

BUREAU V. S.

JAN 28 1958

RECEIVED

State of Maryland

792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & QUEEN ANNE'S</u>		d. STREET ADDRESS <u>1202 LYNCHBURG</u>	
3. NAME OF DECEASED (Type or print) First <u>DELIA</u> Middle <u>HOLLEY</u> Last <u>HOLLEY</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 3, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u>	IF UNDER 24 HRS. Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>KENT, MARYLAND</u>
13. FATHER'S NAME <u>LEWIS HOLLEY</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE MITCHELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL CHART</u>	
17. INFORMANT <u>HOSPITAL CHART</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RENAL ARTERIOSCLEROSIS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETIC GANGRENE, LEG</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 7</u> , 19 <u>58</u> , to <u>JAN 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN 7</u> , 19 <u>58</u> , and that death occurred at <u>4:15</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESTERTOWN, Md.</u> DATE SIGNED <u>1-7-58</u>			
ACTUAL SIGNATURE <u>C. T. Keefe</u> M.D. <u>CHESTERTOWN, Md.</u>		DATE SIGNED <u>1-7-58</u>	
PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>James Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR <u>JAN 13 '58</u> DATE
			24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Note. Corrections made at Kent and Queen Anne's Hospital
Record Room.

R. M. Bowles. M. R. R.

BUREAU V. S.

JAN 13 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00793

892

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN 1b 55 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle James Last Hopkins		4. DATE OF DEATH Month January Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1877
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-8575	
17. INFORMANT Norman Hopkins		Address Kennedyville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/11 , 19 57 , to 1/10 , 19 58 , that I last saw the deceased alive on 1/10 , 19 58 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/10/58			
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Thomas Solon		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/12/58	22c. NAME OF CEMETERY OR CREMATORY Crumpton Cemty	22d. LOCATION (City, town, or county) (State) Crumpton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 13 1958

RECEIVED

Robert R. Taylor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove corban papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

793

CERTIFICATE OF DEATH

Reg. Dist. No.

00794

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lelia Middle H. Last Hossinger		4. DATE OF DEATH Month January Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. BIRTHPLACE (State or foreign country) U.S.A.		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME Lewis S. Hepburn		15. MOTHER'S MAIDEN NAME Mary E. Roseberry	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Hospital records, Chestertown, Md.		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Old age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old age (c) Old age INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15 , 19 58 , to Jan. 29 , 19 58 , that I last saw the deceased alive on Jan. 28 , 19 58 , and that death occurred at 10:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1-29-58			
ACTUAL SIGNATURE A.C. Dick		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-1-58	
22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMT		22d. LOCATION (City, town, or county) (State) STILL POND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy		ADDRESS STILL POND, MD.	
24a. REC'D BY REGISTRAR DATE JAN 31 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

CERTIFICATE OF DEATH

Reg. Dist. No.

00795

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE First Scoville Middle Lloyd Last		4. DATE OF DEATH JAN 17 1958 Month JAN Day 17 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 16, 1887 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) CHICAGO, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME AMASA C. Scoville	
14. MOTHER'S MAIDEN NAME MAY Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT SHERMAN C Lloyd Sr. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X UREMIA DUE TO CEREBRAL VASCULAR ACCIDENTS DUE TO ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8424 , 19 53 , to Jan 17 , 19 58 , that I last saw the deceased alive on Jan 17 , 19 58 , and that death occurred at 8:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence Deringer Joyce M.D.		ADDRESS (Street, city or town, state) Worton, Md DATE SIGNED Jan 17, 1958	
PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE		WORTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-20-58	22c. NAME OF CEMETERY OR CREMATORY WILMINGTON + BRANDYWINE	22d. LOCATION (City, town, or county) (State) WILMINGTON DEL.
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR JAN 20 '58	24b. REGISTRAR'S SIGNATURE Alfred...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Victor H. Kennedy, 2111 1st St., MD

BURIAL 1-20-28 WILMINGTON + BRANDWINE WILMINGTON

WILMINGTON, MD JAN 20 1958

FLORENCE BERINGER JONES

Florence Beringer Jones

Jan 17 28

ONLY

Jan 17 28

RECEIVED

BACTERIOLOGIC

GENERAL VASCULAR ACCIDENTS

NEURALGIA

NO

AMAZA (L. SCOVILLE)

MAY WILLIAMS

HOME

NONSENSE

CHANCE, ILLINOIS

JAN 17 28

FLORENCE SCOVILLE

JAN 17 28

JAN 17 28

WEST

BESTER

1/2

BESTER

WILMINGTON

WEST

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

794

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Abbie Estella Quinn First Middle Last				4. DATE OF DEATH Jan. 19, 1958 Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 2, 1876	
9. AGE (In years day birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Queen Anne Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME Joseph Loller				14. MOTHER'S MAIDEN NAME Kathryn Pardee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Mary Bonwill Still Pond, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - Cardiovascular DUE TO Arterio Sclerosis (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 1 - 1957 , to Jan 19 1958 , that I last saw the deceased alive on Jan 19 1958 , and that death occurred at 1:58 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Norbert C. Nitsch M.D. Robert Hall PHYSICIAN'S NAME (Type) NORBERT C. NITSCH Maryland							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 21 1958	
				24b. REGISTRAR'S SIGNATURE Robert Hall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1908		Baltimore		Maryland		United States			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Carpenter		Heart Disease		Natural		1953		Baltimore		Maryland		United States			
EDUCATION		RELIGION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
High School		Roman Catholic		Married		1930		Baltimore		Maryland		United States			
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
John H. Harris		Mary E. Harris		Carpenter		Homemaker		Maryland		Maryland		1875		1885	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		DATE		PLACE		CITY		STATE		COUNTRY			
James H. Harris		John J. Harris, M.D. Mary E. Harris		1953		Baltimore		Maryland		United States					

BUREAU V. S.

JAN 21 1953

RECEIVED

804

CERTIFICATE OF DEATH

00797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecil</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>LINDA</i> Middle <i>M.</i> Last <i>SMITH</i>				4. DATE OF DEATH Month <i>Jan</i> Day <i>26</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 27 1873</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>Phila. Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa</i>	
13. FATHER'S NAME <i>Samuel L Hoover</i>				14. MOTHER'S MAIDEN NAME <i>Julia McCurdy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Wm Mac Muffin</i>				Address <i>Baltimore md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive metastases</i> <i>170x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Breast Carcinoma (rt Breast)</i> DUE TO (c) <i>massive pleural effusion secondary to above.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>3 years.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>massive pleural effusion secondary to above.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Oct 15</i> , 19 <i>58</i> , to <i>Jan 26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 26</i> , 19 <i>58</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wallace Obenshain</i> M.D.				ADDRESS (Street, city or town, state) <i>Cecil, Md.</i> DATE SIGNED <i>27 Jan 58</i>			
PHYSICIAN'S NAME (Type) <i>WALLACE OBENSHAIN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Jan 28 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cecil Am</i>		22d. LOCATION (City, town, or county) (State) <i>Cecil md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Yellow</i> ADDRESS <i>Wilmington md.</i>				24a. REC'D BY REGISTRAR <i>Jan 31 58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU

15 JAN 31 1958

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00798

805

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS 16 Hawthorne Ave;	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Lillian Last Smith		4. DATE OF DEATH Month Jan. Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Legg		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Wm. Smith--Rock Hall, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular DUE TO (c) Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1957 , to Jan 11, 1958 , that I last saw the deceased alive on Jan 11, 1958 , and that death occurred at 11:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Norbert C. Nitsch M.D. Robert Hill PHYSICIAN'S NAME (Type) NORBERT C. NITSCH Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE JAN 20 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

BUREAU V. 51

IAN 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

806

CERTIFICATE OF DEATH

00799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Belle Last Spurgin				4. DATE OF DEATH Month Jan. Day 26 Year 1959			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12 1867		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Bolling Green Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sanford Reynolds				14. MOTHER'S MAIDEN NAME Ann Lloyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. C. J. Black Address Kennedville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HT. DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILITY DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/7 , 19 56 , to 1/26 , 19 58 , that I last saw the deceased alive on 1/17 , 19 58 , and that death occurred at 3:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Elliott				ADDRESS (Street, city or town, state) 212 West St. Laurel Md.		DATE SIGNED 1/26/58	
PHYSICIAN'S NAME (Type) JOSEPH A. ELLIOTT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) near Fairlee, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.				24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE Carl Smith	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TOP ONE SIX

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. OCCUPATION [REDACTED]		8. MARITAL STATUS [REDACTED]		9. EDUCATION [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. CAUSE OF DEATH [REDACTED]	
13. MEDICAL HISTORY [REDACTED]		14. PRESENT ILLNESS [REDACTED]		15. TIME OF DEATH [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CLERK [REDACTED]		20. SIGNATURE OF REGISTRAR [REDACTED]		21. SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. 1

JAN 28 1958

RECEIVED

807

CERTIFICATE OF DEATH

Reg. Dist. No. 00800

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betterton</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---				d. STREET ADDRESS <u>1</u> ---			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Sutton</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 18, 1864</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Carvel Sutton</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Arthur G. Sutton, Chester, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>70 or 15-</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Jan 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>58</u> , and that death occurred at <u>6:30 p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u>		M.D. <u>Cecilton</u>		ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u>		DATE SIGNED <u>4 Jan 58</u>	
PHYSICIAN'S NAME (Type) <u>WALLACE OBENSHAIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/ 6/ 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Kennedyville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u>		ADDRESS <u>Still Pond, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten and printed text.

Victor J. Kennedy

RECEIVED

JAN 8 1938

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00801

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b several d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Nelson Urie		4. DATE OF DEATH Jan. 29 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1899 May 9, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired fireman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Fire Dept.	
11. BIRTHPLACE (State or foreign country) XXXXX Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Urie		14. MOTHER'S MAIDEN NAME Anna Downey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lawrence Urie, Rock Hall, Md. (brother)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown but probable heart attack DUE TO Went to his room for the night 1/28/58 at 10:00P.M. Found dead in the floor at the foot of his bed 8:00A.M. 1/29/58. Has always been in good health and was apparently well when he retired. Has had no pain in chest Conditions, if any, which gave rise to immediate cause (b) shortness of breath or indigestion. Rigormortis was complete (c) stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) when he was found.		INTERVAL BETWEEN ONSET AND DEATH very short	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr, M. D.		DATE SIGNED 1/29/58	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 1		22b. DATE THEREOF Feb. 1	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill, Md.		24a. REC'D BY REGISTRAR Feb 4 '58	
24b. REGISTRAR'S SIGNATURE md			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00802

795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill	
c. LENGTH OF STAY IN 1b 4 days		d. STREET ADDRESS 17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTELLE Middle WALLS Last WALLS		4. DATE OF DEATH Month January Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel C Walls		14. MOTHER'S MAIDEN NAME Mary Rigby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension, & Hypertensive cardiovascular Disease DUE TO (c) Many years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 28 , 19 57 , to Jan 1 , 19 58 , that I last saw the deceased alive on January 1 , 19 58 , and that death occurred at 10:35 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Maryland	
DATE SIGNED Jan 1, 1958			
PHYSICIAN'S NAME (Type) ROBERT W. FARR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF JAN 3	22c. NAME OF CEMETERY OR CREMATORY Church Hill	22d. LOCATION (City, town, or county) (State) Church Hill Ind.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		24a. REC'D BY REGISTRAR Jan 6 1958	
ADDRESS Church Hill		24b. REGISTRAR'S SIGNATURE A. Hedrick	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. JONES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1923		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1945		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPOUSE Mary A. Jones	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH 1958		14. PLACE OF DEATH Home		15. SIGNATURE OF DECEASED (None)	
16. SIGNATURE OF PHYSICIAN J. A. Smith		17. SIGNATURE OF WITNESS J. B. Brown		18. SIGNATURE OF DECEASED (None)		19. SIGNATURE OF SPOUSE Mary A. Jones		20. SIGNATURE OF OTHER (None)	
21. NAME OF PHYSICIAN J. A. Smith		22. NAME OF WITNESS J. B. Brown		23. NAME OF DECEASED JAMES A. JONES		24. NAME OF SPOUSE Mary A. Jones		25. NAME OF OTHER (None)	
26. ADDRESS OF DECEASED 123 Main St.		27. ADDRESS OF SPOUSE 123 Main St.		28. ADDRESS OF OTHER (None)		29. ADDRESS OF PHYSICIAN 456 Main St.		30. ADDRESS OF WITNESS 789 Main St.	
31. ADDRESS OF DECEASED 123 Main St.		32. ADDRESS OF SPOUSE 123 Main St.		33. ADDRESS OF OTHER (None)		34. ADDRESS OF PHYSICIAN 456 Main St.		35. ADDRESS OF WITNESS 789 Main St.	
36. ADDRESS OF DECEASED 123 Main St.		37. ADDRESS OF SPOUSE 123 Main St.		38. ADDRESS OF OTHER (None)		39. ADDRESS OF PHYSICIAN 456 Main St.		40. ADDRESS OF WITNESS 789 Main St.	
39. ADDRESS OF DECEASED 123 Main St.		40. ADDRESS OF SPOUSE 123 Main St.		41. ADDRESS OF OTHER (None)		42. ADDRESS OF PHYSICIAN 456 Main St.		43. ADDRESS OF WITNESS 789 Main St.	
44. ADDRESS OF DECEASED 123 Main St.		45. ADDRESS OF SPOUSE 123 Main St.		46. ADDRESS OF OTHER (None)		47. ADDRESS OF PHYSICIAN 456 Main St.		48. ADDRESS OF WITNESS 789 Main St.	
49. ADDRESS OF DECEASED 123 Main St.		50. ADDRESS OF SPOUSE 123 Main St.		51. ADDRESS OF OTHER (None)		52. ADDRESS OF PHYSICIAN 456 Main St.		53. ADDRESS OF WITNESS 789 Main St.	
54. ADDRESS OF DECEASED 123 Main St.		55. ADDRESS OF SPOUSE 123 Main St.		56. ADDRESS OF OTHER (None)		57. ADDRESS OF PHYSICIAN 456 Main St.		58. ADDRESS OF WITNESS 789 Main St.	
59. ADDRESS OF DECEASED 123 Main St.		60. ADDRESS OF SPOUSE 123 Main St.		61. ADDRESS OF OTHER (None)		62. ADDRESS OF PHYSICIAN 456 Main St.		63. ADDRESS OF WITNESS 789 Main St.	
64. ADDRESS OF DECEASED 123 Main St.		65. ADDRESS OF SPOUSE 123 Main St.		66. ADDRESS OF OTHER (None)		67. ADDRESS OF PHYSICIAN 456 Main St.		68. ADDRESS OF WITNESS 789 Main St.	
69. ADDRESS OF DECEASED 123 Main St.		70. ADDRESS OF SPOUSE 123 Main St.		71. ADDRESS OF OTHER (None)		72. ADDRESS OF PHYSICIAN 456 Main St.		73. ADDRESS OF WITNESS 789 Main St.	
74. ADDRESS OF DECEASED 123 Main St.		75. ADDRESS OF SPOUSE 123 Main St.		76. ADDRESS OF OTHER (None)		77. ADDRESS OF PHYSICIAN 456 Main St.		78. ADDRESS OF WITNESS 789 Main St.	
79. ADDRESS OF DECEASED 123 Main St.		80. ADDRESS OF SPOUSE 123 Main St.		81. ADDRESS OF OTHER (None)		82. ADDRESS OF PHYSICIAN 456 Main St.		83. ADDRESS OF WITNESS 789 Main St.	
84. ADDRESS OF DECEASED 123 Main St.		85. ADDRESS OF SPOUSE 123 Main St.		86. ADDRESS OF OTHER (None)		87. ADDRESS OF PHYSICIAN 456 Main St.		88. ADDRESS OF WITNESS 789 Main St.	
89. ADDRESS OF DECEASED 123 Main St.		90. ADDRESS OF SPOUSE 123 Main St.		91. ADDRESS OF OTHER (None)		92. ADDRESS OF PHYSICIAN 456 Main St.		93. ADDRESS OF WITNESS 789 Main St.	
94. ADDRESS OF DECEASED 123 Main St.		95. ADDRESS OF SPOUSE 123 Main St.		96. ADDRESS OF OTHER (None)		97. ADDRESS OF PHYSICIAN 456 Main St.		98. ADDRESS OF WITNESS 789 Main St.	
99. ADDRESS OF DECEASED 123 Main St.		100. ADDRESS OF SPOUSE 123 Main St.		101. ADDRESS OF OTHER (None)		102. ADDRESS OF PHYSICIAN 456 Main St.		103. ADDRESS OF WITNESS 789 Main St.	

BUREAU V. 3

JAN 6 1958

RECEIVED

796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank Zungaila		4. DATE OF DEATH Month January Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1893
9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 58	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		12. KIND OF BUSINESS OR INDUSTRY Lithographer	
13. FATHER'S NAME John Zungaila		14. MOTHER'S MAIDEN NAME Catherine Martinkis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Don't know		16. SOCIAL SECURITY NO. Don't know	
17. INFORMANT Hospital Records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Congestive Heart Failure & Bronchopneumonia 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation & Probable Exposure DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. Month 19 Day 19 Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan/5, 1958 , to Jan. 10, 1958 , that I last saw the deceased alive on January 10, 1958 , and that death occurred at 6:00A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		DATE SIGNED 1/10/58	
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24. REC'D BY REGISTRAR Jan 13 '58	
ADDRESS Chestertown, Md.		25. REGISTRAR'S SIGNATURE Chas. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 15, 1880		PLACE OF BIRTH Boston, Mass.	
MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married	
OCCUPATION Teacher		OCCUPATION Teacher		OCCUPATION Teacher		OCCUPATION Teacher		OCCUPATION Teacher		OCCUPATION Teacher	
DATE OF DEATH Jan 18, 1928		DATE OF DEATH Jan 18, 1928		DATE OF DEATH Jan 18, 1928		DATE OF DEATH Jan 18, 1928		DATE OF DEATH Jan 18, 1928		DATE OF DEATH Jan 18, 1928	
PLACE OF DEATH Boston, Mass.		PLACE OF DEATH Boston, Mass.		PLACE OF DEATH Boston, Mass.		PLACE OF DEATH Boston, Mass.		PLACE OF DEATH Boston, Mass.		PLACE OF DEATH Boston, Mass.	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Dr. J. A. Smith		SIGNATURE OF PHYSICIAN Dr. J. A. Smith		SIGNATURE OF PHYSICIAN Dr. J. A. Smith		SIGNATURE OF PHYSICIAN Dr. J. A. Smith		SIGNATURE OF PHYSICIAN Dr. J. A. Smith		SIGNATURE OF PHYSICIAN Dr. J. A. Smith	
SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF REGISTRAR John Doe	
DATE OF REGISTRATION Jan 19, 1928		DATE OF REGISTRATION Jan 19, 1928		DATE OF REGISTRATION Jan 19, 1928		DATE OF REGISTRATION Jan 19, 1928		DATE OF REGISTRATION Jan 19, 1928		DATE OF REGISTRATION Jan 19, 1928	
PLACE OF REGISTRATION Boston, Mass.		PLACE OF REGISTRATION Boston, Mass.		PLACE OF REGISTRATION Boston, Mass.		PLACE OF REGISTRATION Boston, Mass.		PLACE OF REGISTRATION Boston, Mass.		PLACE OF REGISTRATION Boston, Mass.	

BUREAU V.

JAN 19 1928

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